

Letters

COVID-19 and education in regional anesthesia

To the Editor

We read with special interest the recent article by Ashokka *et al* titled “Reconfiguring the scope and practice of regional anesthesia (RA) in a pandemic: the COVID-19 perspective”¹ and we are thankful for its contribution. The concern about the anesthesiologist and healthcare team’s safety when performing general anesthesia (GA) is real, due to exposition to aerosolized particles and potential dispersion of the virus during airway-instrumentation. Since COVID-19 transmission has proven to occur from both symptomatic and asymptomatic patients, RA, which is non-aerosol generating, should be considered whenever the surgical procedure and patient’s condition are suitable for it.² Ashokka *et al* wisely recommend preoperative risk stratification with the use of point-of-care ultrasound to assess the extent of COVID-19 disease for therapeutic purposes and to help in the decision making of which patients could potentially receive RA versus GA techniques.¹ Recommendations on how to perform RA procedures include: performing the procedure in the operating theater, limiting the number of personnel present, and that the most experienced person should execute the procedure.³

We would like to call the attention to the fact that these challenging conditions will undoubtedly minimize residents teaching and exposure to RA procedures. As we aim for them to be done by high-experienced clinicians in order to decrease the risk of failure and the possibility of specific complications (Ej. pneumothorax and conversion to GA),⁴ we are also reducing the options of trainees to learn how to perform them. This situation may have important education repercussions, especially in low-income countries with high-rates of the virus circulating within the community, where all-patients admitted for surgical care are treated as suspects, since preoperative testing is not an available option.

As a consequence, anesthesia residents will experience a dramatic drop in the exposure to all aspects of their RA training, leading to potentially negative effects on their training in the near future.⁵ One of the possibilities to overcome this obstacle is to adapt simulation techniques to ensure

high-quality RA education. This needs to be done to maintain safety and wellness of learners, educators and patients.

Virtual education has an important role. Strategies such as watching didactic material and high-quality RA videos prior to periodic teleconferences for questions and discussion, could partially help with the problem. Simulation needs to be encouraged in practicing technical skills in RA procedures and crisis management scenarios. Clinical-simulated situations that include live-threatening conditions also represent an opportunity to practice rapid control of airway and cardiopulmonary resuscitation with the appropriate use of personal protective equipment amidst the lack of operative cases.¹ During this rapidly evolving crisis, a great deal of flexibility will be required from both learners and educators, by offering alternative approaches, allowing free and easy access to surgical video libraries, and encouraging RA societies to share their resources with residency programmes and anesthesiologist in order to maintain rigorous standards of education and training in RA procedures.

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